State of Indiana
Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
One American Square, P.O. Box 368
Group State of Indiana
Indianapolis, IN 46206-0368
1-800-673-3216
www.employeebenefits.aul.com

OneAmerica®

COMPLETE THIS FORM IF YOU AND/OR YOUR DEPENDENTS ARE:

1. Applying for basic, supplemental, and/or dependent life insurance coverage under the State of Indiana's group life insurance contract and the application will be received by AUL after:
   a. the Monday following the end of the employee's first pay period for those agencies not directly billed by AUL; or
   b. thirty-one (31) calendar days following the date of hire for agencies directly billed by AUL.
2. Applying for an increase in the amount of supplemental or dependent life insurance coverage.
3. Applying for dependent life insurance coverage thirty (30) days following the date the individual can be classified as a dependent.

Note: Basic life insurance coverage is a prerequisite of approval of supplemental life insurance coverage. Basic life insurance and supplemental life insurance coverages are prerequisites for approval of dependent life insurance coverage. Any employee who did not apply for coverage during the designated enrollment period, cannot apply until the next annual enrollment period and is required to submit Evidence of Insurability, undergo medical underwriting, and receive approval from AUL before any coverage will exist.

Notices Affecting Coverages

Disclosure Notices

Notice of Insurance Information Practices

Thank you for your request for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells you how information is gathered to review your application.

To issue an insurance contract we need to obtain information about you. Some of that information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. When signed, the Authorization and Acknowledgment will allow us to obtain this information and to share it with others when necessary. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may have to be disclosed to others without your further consent.

You have the right to review and to correct this information, and you have the right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to: Group Underwriting Department, American United Life Insurance Company®, Post Office Box 368, Indianapolis, Indiana 46206-0368.

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file.You can contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact the MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is (866) 692-6901.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim may be submitted.

Fair Credit Reporting Act Notice

We may request an investigative consumer report. These reports contain information about your character, general reputation, personal characteristics, mode of living and health, except as may be related directly or indirectly to your sexual orientation. The information may be obtained through interviews with you, your employer, neighbors, friends and others who know you. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

Fraud Notice

Fraud Notice: Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction.

PLEASE DETACH AND RETAIN THIS SECTION FOR YOUR FILES AND SUBMIT REMAINING SECTION.

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For AUL Office Use Only

☐ *Summary Billed* *Agency Number* _____ *Name of Agency* _____

☐ *List Billed* *Policy Number* _____ *Address of Agency* _____

A. General Employee Information

Name _____ Date of Birth _____

Complete Home Address _____

Work Phone Number _____ Home Phone Number _____

Social Security Number _____ Annual Base Salary _____

B. Complete Only For Those Requesting Coverage

Insured/Employee Name (Last, First, Middle)	Birth Place	DOB	Sex	Height	Weight
Spouse Name (Last, First, Middle)	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle) Relationship to You	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle) Relationship to You	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle) Relationship to You	Birth Place	DOB	Sex	Height	Weight

C. Medical Questions

1. Within the past 7 years, have you or your dependents been diagnosed or treated by a physician or qualified professional, or tested positive for the presence of, or taken prescribed medicine for:

	Employee		Spouse/Dep.			Employee		Spouse/Dep.	
	Yes	No	Yes	No		Yes	No	Yes	No
a. Cancer	☐	☐	☐	☐	j. Kidney/Bladder/Pancreatic Disease	☐	☐	☐	☐
b. Diabetes or other Glandular Disorders	☐	☐	☐	☐	k. Prostate/Reproductive Organ Disorder	☐	☐	☐	☐
c. Chest Pain or Heart Attack	☐	☐	☐	☐	l. Neurological or Brain Disorder including Epilepsy or Paralysis	☐	☐	☐	☐
d. Heart Disease or Disorder including Murmurs	☐	☐	☐	☐	m. Psychological/Emotional Disorder or Depression	☐	☐	☐	☐
e. High Blood Pressure Last Reading _____ Date _____	☐	☐	☐	☐	n. Lung or Respiratory Disorder/Disease	☐	☐	☐	☐
f. Anemia or Blood Disorders (except HIV)	☐	☐	☐	☐	o. Neuromuscular or Musculoskeletal Disorders including Arthritis and Back Disorders	☐	☐	☐	☐
g. Liver Disorder or Hepatitis	☐	☐	☐	☐	p. Skin or Lymph Gland Disorders	☐	☐	☐	☐
h. Stomach and/or Intestinal Disorders	☐	☐	☐	☐	q. Eye, Ear, Nose and Throat Disorders	☐	☐	☐	☐
i. Stroke	☐	☐	☐	☐	r. Any sexually transmitted disease (except HIV)	☐	☐	☐	☐

2. *Within the past 7 years, have you or your dependents been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or immune deficiency related disorders or tested positive for antibodies to the HIV virus? ☐ Yes ☐ No

*Residents of the following states are not required to answer the above question with regard to the following diagnosis or test: ME and GA - immune deficiency related disorders; MI and VT - ARC or HIV; NC - ARC; NJ - HIV; WI - HIV testing other than FDA approved.

3. Within the past 5 years, have you or your dependents:

	Employee		Spouse/Dep.	
	Yes	No	Yes	No
a. Taken or currently take any prescription medicine? If yes, state medicine and the reason for using it in question 5.				
b. Had an electrocardiogram, x-ray, blood study, urinalysis or any other diagnostic study?				
c. Been rejected, rated, postponed or modified for life insurance?				
d. Received or been instructed to seek treatment for use or abuse of alcohol or drugs?				
e. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates or any other habit forming drugs?				
f. Had any illness, injury, operation or treatment other than stated above?				

4. a. Name(s), Address(es) and Phone number(s) of your and/or your dependent(s), personal physician(s) and any specialists seen in the last 3 years:

_____

_____

_____

b. Date and reason last consulted _____

c. What treatment was given or medication provided _____

5. Describe details of "Yes" answers to Questions 1, 2, 3, or 4. If needed, use separate sheet of paper.

Name	Ques. #	Date	Detail of injury, illness or disorder	Name/Address of Physician/Hospital

Authorization and Acknowledgment: I authorize any physician, medical practitioner, hospital, medical facility, insurance company, DMV, and MIB to give to any OneAmerica® company and their reinsurers any of the following about me, or my dependents if they are to be insured: facts about physical and mental health; medical care, advice or treatment; hobbies; other insurance; flying and driving records (which may include but is not limited to existing address); age, occupation, and income; and the use of alcohol, drugs and tobacco. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the AIDS virus. All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine if I am eligible for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for twenty-four (24) months from the date I signed the application. I can choose to be interviewed if an investigative consumer report is made. I, or my authorized representative, can receive a copy of this authorization form.

I represent that the statements and answers given on this form are true and complete to the best of my knowledge and belief. I understand and agree that any insurance which shall be issued is in consideration of these statements being complete and correct. I certify that the notices attached were read and understood prior to the completion of this form, and that I have retained these notices for my records.

_____ _____

Signature of Insured/Employee Date Signature of Spouse Date

_____

Signature of Eligible Child 18 or over Date